AMELIA A. PARÉ, M.D.
PATIENT REGISTRATION **Date of visit**:_____

PATIENT INFORMATION (PLEASE PRINT)
Name:_____
Date of Birth: _____Age:_____Male____Female_____Race_____
Social Security #: _____ Marital Status: Single Married Divorced Widowed
Street Address:_____
City, State, Zip Code: _____
Home Phone:_____Cell Phone:_____Work Phone:_____

If you are prescribed any medications, where would you like the script sent?
Pharmacy Name:_____ **Pharmacy Phone**:_____

Occupation: _____ Employer: _____
Employer's Address: _____
Spouse or Parent's name if under 18 yo:_____

Emergency Contact:_____Relationship_____ Phone Number: _____

May we leave a message at home on your **voice mail/answering machine** or with a **family member** to return our call? **Yes_____No_____**
May we leave medical information with a family member? **Yes__ No__**Name_____
May we contact you at work? **Yes____No_____**

Family Physician name_____ **Family Physician Phone#**_____
Were you referred by your family physician? Yes___No__
Other Source of Referral_____

INSURANCE / BILLING INFORMATION
Primary Insurance Co_____
Policy Number: _____ Group Number:_____
Insurance Company Phone Number: _____
Address:_____
Policy Holder Name:_____**SS** #_____
Date of Birth: _____ Relationship To Insured_____

Secondary Insurance Co_____
Policy Number: _____ Group Number:_____
Insurance Company Phone Number: _____
Address:_____
Policy Holder Name: _____ **SS** #_____
Date of Birth: _____ Relationship To Insured_____

Authorization: I hereby authorize Dr. Amelia Arianne Paré to furnish information to insurance carriers and/or health care providers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.
Signature of Responsible Party:_____Date_____

Authorization: I hereby authorized Amelia Paré to take my photograph and use it in my charts and for teaching purposes.
Signature of Responsible Party:_____Date_____

Name:_____ Date of Birth:_____ Height_____ Weight_____
Please briefly explain the reason for this visit:_____
Drug Allergies:_____
Latex Allergy: No_____ Yes_____ Blood test drawn to verify latex allergy No_____ Yes_____
Current Medications:_____
_____
_____
_____
Vitamins or herbal Supplements:_____
Do you or any family member have a bleeding problem or a blood disorder? No_____Yes_____
If yes, please explain_____
List all medical conditions:_____
_____
List all previous hospitalizations:_____
List all operations:_____
_____
Have you experienced any of the following medical conditions? If yes, please explain.
Yes No Chest pain or pressure:_____
Yes No Shortness of breath, asthma or wheezing:_____
Yes No Frequent and Severe headaches:_____
Yes No Nausea and/or vomiting:_____
Yes No Dizziness and/or fainting:_____
Yes No Seizures:_____
Yes No Weight loss:_____
Yes No Change in vision:_____
Yes No Swelling in legs or feet:_____
Yes No Blood Clots and/or circulation problems:_____
Yes No Heart Murmur or History of Rheumatic Fever:_____
Yes No Sinus Problems:_____
Yes No Diabetes:_____
Yes No High Blood Pressure:_____
Yes No High Cholesterol:_____
Yes No Stroke:_____
Yes No Hepatitis:_____
Yes No Renal Disorders:_____
Yes No Cancer:_____
Yes No Sexually Transmitted Disease:_____
Yes No Keloids:_____
Yes No Wound Healing Problems:_____
Yes No MRSA:_____
Yes No Burning, itchy, or dry eye and/or excessive tearing:_____
Yes No Snoring and/or Sleep Apnea:_____
Yes No Anxiety:_____
Yes No Depression:_____
Yes No Do you smoke? Packs per day x # of years:_____
Yes No Do you consume alcohol? Amount:_____
Family History:
Diabetes No___ Yes____, and who?_____
Heart Disease No___ Yes____, and who? _____
Stroke No___ Yes____, and who?_____
Cancer No___ Yes____, and who and type?_____
Problems w/ Anesthesia No___ Yes____, and who?_____

Amelia Paré, MD

Acknowledgement of Receipt of Notice of Privacy Practices/Consent to Treat

Amelia Paré, M.D. has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our Privacy Officer.

How to contact our Privacy Officer:
Mail: Amelia Paré, M.D.
123 Hidden Valley Road
McMurray, PA 15317
Phone: 724-941-8838
Fax: 724-941-8878

Acknowledgment of Receipt and Consent

I, _____(relationship)_____, give my consent to the practitioners of Amelia Paré, M.D. to perform medical services determined to be necessary or advisable for the benefit of my health care. I acknowledge that I have received the Notice of Privacy Practices for Amelia Paré M.D. Amelia Paré, M.D. is authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

_____
Signature of patient (or personal representative)

Medicare Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to Medicare for payment to me.

_____
Signature of patient (or personal representative)

OFFICE FINANCIAL POLICY

Thank you for choosing us as your Health Care Provider. We are committed to helping you receive the best possible treatment available. Please understand that payment of your bill is considered a part of your treatment. Due to the vast amount of insurance plans, it is impossible for us to be aware of each patient's coverage. Please be aware of any benefits limitations your plan may have. If we do verify your benefits, and obtain authorization, please understand that this is still NO guarantee of payment or that the information that we are given is correct. We are NOT responsible for insurance company errors. It is your responsibility to pay any co-pays, deductible amounts, co-insurance or any balance left unpaid by your insurance company at the time of treatment. **Please be advised: Please make sure we have your current insurance information at your initial visit.**

Today's Method of Payment (Please check one)
Cash___ Check___ Credit Card (Visa or Mastercard)___
We will bill your insurance if Dr. Paré is participating with your plan.

I have read this financial policy. I understand and agree to this policy.

_____
Signature of patient (or personal representative)

Please complete a separate form for each person we can disclose information to including your family doctor. Thank You.

Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ Date of Birth: _____

Entity Requested to Release Information:

Dr Amelia Paré

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.